Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	004686	A. BUILDING _____ B. WING _____	05/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON HOUSE	2116 BUTLER RD FORT WAYNE, IN 46815

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. Survey dates: May 10 and 11, 2012 Facility number: 004686 Provider number: 004686 AIM number: N/A Survey team: Diane Nilson, RN, TC Julie Call, RN Virginia Terveer, RN Census bed type: Residential: 31 Total: 31 Census payor type: Private: 31 Total: 31 Sample: 7 Hamilton House was found to be in compliance with 410 IAC 16.2 in regard to the State Residential Licensure Survey. Quality review completed on May 14, 2012 by Bev Faulkner, R.N.	R 000		